PLAN AMENDMENT

Plan Name: City of Auburn Medical and Prescription Drug Plan

Plan Number: 501

Effective Date: January 1, 2009

The sections entitled "Comprehensive Medical Benefits" and "Miscellaneous Benefits" in the Schedule of Benefits section of the Plan are deleted in its entirety and replaced with the following:

Comprehensive Medical Benefits

Provision	Signature Care EPO Special Access Providers	Signature Care PPO Providers	Non-PPO Providers	Maximums/Notes
Individual Deductible	$500	$1,500*	$3,500	Applies per person calendar year
Family Deductible Limit	$1,500	$4,500*	$10,500	Eligible charges for family members who are covered under the Plan may be applied toward satisfaction of the family deductible limit, however, no more than the individual amount specified any one individual will be applied toward the family deductible limit.
**** The additional deductible amounts only apply for Network Facilities <u>not</u> affiliated with the EPO Network.*** *EPO (Tier 1) Hospitals include: Parkview Hospitals, Parkview Noble, Parkview Whitley Hospital, Parkview LaGrange Hospital, Parkview Huntington Hospital, Parkview North Hospital, and Orthopedic Hospital at Parkview North, Parkview Behavioral Health, Wabash County Hospital, Cameron Hospital, Adams County, and Dekalb County Hospital.*				
Coinsurance Paid By the Plan	80%	80% or 60%*	40%	***<u>Applies to facility fees not affiliated with the EPO Network.</u>*** ***<u>All professional fees will remain at 80%</u>*** unless otherwise specified by the Plan, up to the Maximum Allowable Amounts

Provision	Signature Care EPO Special Access Providers	Signature Care PPO Providers	Non-PPO Providers	Maximums/Notes
Maximum Out-of-Pocket Amounts	Individual: $1,500 Family: $4,500	Individual: $3,500 Family: $10,500	No Limit	Unless otherwise specified by the Plan, after satisfaction of the out-of-pocket-amounts, eligible services will be covered at 100% for the remainder of the calendar year. Eligible charges for the following will not be applied toward satisfaction of the Maximum-Out-of-Pocket Amounts: • any deductible amounts; • any penalty amounts; • any preventative and/or routine care charges; • any chiropractic charges; • any charges not covered by the Plan; and • any changes for Mental Health and Substance Abuse. EPO Benefits **can** be applied toward the PPO benefit level.
PPO/Non-PPO Exceptions	**Only under the following circumstances will benefits be determined at the EPO rather than the Non-PPO benefit level:** 1. when a covered person requires medical care and there is not an EPO provider available; 2. when medical care is necessary due to an emergency. An emergency is defined as a sudden and severe onset of life threatening symptoms such as fainting, difficult breathing, chest pain, allergic reaction or accidental injury; 3. when a covered person receives medical care at an EPO hospital or ambulatory surgical center and such facility utilizes the services of a Non-EPO radiologist, anesthesiologist, pathologist, or emergency room physician; or 4. eligible charges for medical services for covered employees who reside outside the EPO Network are and their eligible dependents.			

Miscellaneous Benefits

Provision	Signature Care EPO Special Access Providers	Signature Care PPO Providers	Non-PPO Providers	Maximums/Notes
Chiropractic Care	Deductible/80%	Deductible/80%	Deductible/40%	Limited to a maximum of 20 visits or $2,000 per calendar year, which ever occurs first
Home Health Care	Deductible/80%	Deductible/80%, or 60%	Deductible/40%	Limited to a maximum of 60 visits per calendar year
Human Organ and Tissue Transplant	Deductible/80%	Deductible/80%	Deductible/40%	Limited to the Maximum Benefit of $10,000 for charges incurred for removal, preserving and transportation costs of the donated organ to the extent not covered by the donor's plan
Laboratory Expenses	**Specialty Lab- (Acculab)** 100%	**Specialty Lab- (Acculab)** 100%	**Specialty Lab- (Acculab)** 100%	
	Non-Specialty Lab Deductible/80%	**on-Specialty Lab** Deductible/60%	**Non-Specialty Lab** Deductible/40%	
Mental Health and Substance Abuse Treatment	***Inpatient Mental Health and Substance Abuse Treatment*** Deductible/80%	Deductible/80%, or 60%	Deductible/60%	**Mental Health –** Inpatient/Transitional – limited to 30 days per calendar year Outpatient – limited to 50 visits per calendar year **Substance Abuse-** Inpatient and Outpatient- limited to a combined maximum of $5,000 per person per calendar year
	Outpatient Mental Health and Substance Abuse Treatment Deductible/50%	Deductible/50%	Deductible/50%	

- When multiple charges and diagnoses are received for outpatient services and supplies that have been provided for either or both Mental Health and Substance Abuse, outpatient benefits under the Plan will be determined according to the provider's primary diagnosis listed for that date of service.
- The determination of whether a claim for benefits is covered by and subject to the Mental Health benefit shall be made without regard to whether the cause of the condition for which treatment and supplies were provided is, or was, organic in origin.

Provision	Signature Care EPO Special Access Providers	Signature Care PPO Providers	Non-PPO Providers	Maximums/Notes
Skilled Nursing Facility	Deductible/80%	Deductible/80% or 60%	Deductible/40%	Limited to a maximum 90 days per confinement
Specialty Cardiac Expenses	**Cardiac Pathways Program** 100%	**Non-Specialty Care** Deductible/80%	Deductible/40%	
Supplemental Accident Benefit	100%	100%	100%	Limited to a maximum of $500 per accidental injury Treatment must be rendered within 90 days of the accident date and provided on an outpatient basis After exhaustion of the $500, eligible charges are subject to the deductible and coinsurance amount specified by the Plan
Temporomandibular Joint Dysfunction	Deductible/80%	Deductible/80%	Deductible/40%	Limited to the Maximum Benefit specified by the Plan
The Wellness Benefit	100%	100%	100%	Limited to a maximum benefit of $500 per calendar year. Thereafter, for the remainder of that calendar year, eligible charges will be covered subject to the deductible and coinsurance amounts specified by the Plan. The following routine services are covered: • Examinations; • Pap smears; • Mammograms, once per calendar year; • Other related lab and x-rays; • Well-baby care; and • Preventative immunizations.

The section entitled "Prescription Drug Benefits" in the Schedule of Benefits section of the Plan is deleted in its entirety and replaced with the following:

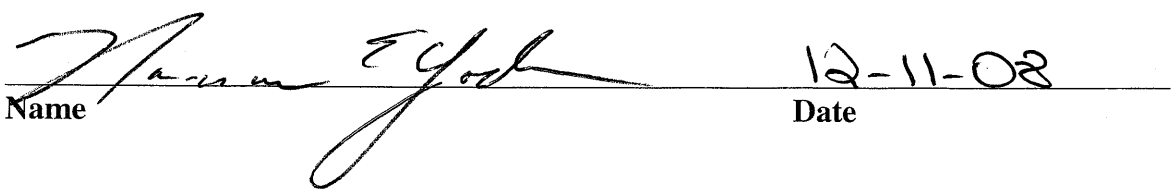
Prescription Drug Benefits

Eligible prescription drugs are payable after satisfaction of the following co-payments:

Provision	Retail Program	Mail Order Program	Maximums/Notes
Prescription Drug Co-payment Amounts	Generic: $10 Preferred Brand: $30 Non-Preferred Brand: $45	Generic: $20 Preferred Brand: $60 Non-Preferred Brand: $90	Dispensing Limitations: Retail Program – not to exceed a 34-day supply* Mail Order – Not to exceed a 90-day supply
Retail Refill Allowance Program	Generic: $20 Preferred Brand: $60 Non-Preferred Brand: $90	n/a	*Limited to a maximum of 3 refills. The 4th refill is subject to the higher co-pay listed. This applies to maintenance prescriptions only.
Mandatory Generic Substitution	The covered person must use generic drugs when they are available, otherwise the covered person must pay the difference between the generic drug cost and the brand name drug cost, in addition to the brand name co-payment amount. If the provider issuing the written prescription or the state in which the covered person resides does not allow generic substitution, the covered person shall be required to pay only the brand name co-payment amount.		

ALL OTHER PROVISIONS OF THE PLAN WILL REMAIN THE SAME.

Approved By: City of Auburn



Name 12-11-08 **Date**